Bureau of Quality Improvement Services (BQIS)

Incident Data and Recommendations

Incident Communication **04/01/2012 through 06/30/2012**

BQIS

Becky Selig
Director
Bureau of Quality
Improvement Services
Division of Disability &
Rehabilitative Services

Phone: 317-234-1147
Fax: 317-232-1240
E-mail: Becky.Selig@fssa.in.gov
WWW.DDRS.IN.GOV

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Introduction

The Division of Disability and Rehabilitative Services (DDRS) Bureau of Quality Improvement Services (BQIS) utilizes an incident reporting and management system as an integral tool in ensuring the health and welfare of people receiving services from one of the three Home and Community-Based Services (HCBS) waivers (AUT, DD, SS) administered by the Bureau of Developmental Disabilities (BDDS).

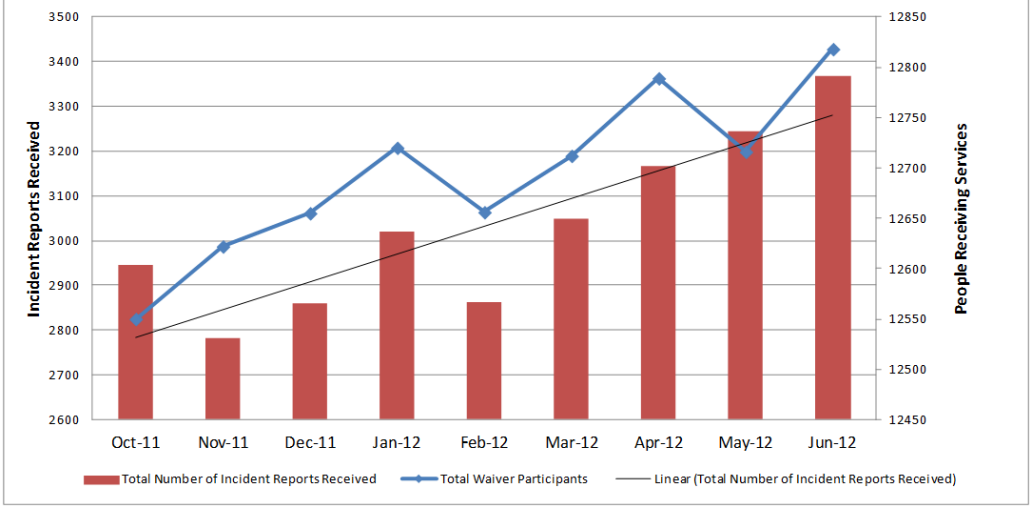
The criteria of a reportable incident can be found in the *DDRS Incident Reporting and Management Policy* located at http://www.in.gov/fssa/files/Incident_Reporting_and_Management.pdf. In addition, there is a webinar presentation and a Frequently Asked Questions (FAQs) document relative to Incident Reporting located on the BQIS website at http://www.in.gov/fssa/ddrs/3838.htm.

This communication provides nine months of selected categories of incident data for people on a waiver. The data are presented in order to share trends and recommendations with the provider community, case managers, and other interested stakeholders.

General Incident Data for People Receiving Waiver Services

The trend line for the reportable incident volume continues to present a steady upward trend since October 2011. The lower volume in November and December is consistent with the past three years of lower numbers of incidents reported during these months. The volume of reported incidents has increased for the past five months.

Figure 1. Reportable Incident Volume - Waiver



General Incident Data (cont.)

The number of people receiving services through each of the three HCBS waivers is presented in Table 1 to be used as a frame of reference.

Table 1. Number of People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
DD Waiver (DD)	7237	7277	7292	7310	7225	7246	7264	7272	7286
AUT Waiver (AUT)	469	487	495	507	508	524	538	547	553
Support Service Waiver (SS)	4844	4858	4868	4903	4923	4942	4987	4897	4979
Total Waiver Participants	12550	12622	12655	12720	12656	12712	12789	12716	12818

Incident Processing

The timelines for incident processing include the provider/mandated reporter submitting an incident report (IR) through the state's web-based application within 24 hours of initial discovery of a reportable incident. BQIS processes the incident report to determine whether or not appropriate and sufficient actions to remedy the situation, prevent chances for recurrence, and to assure the person's immediate safety have been taken. Based on this determination, the incident is either marked as closed or marked as additional follow-up is required. The incident reporting system automatically generates an e-mail to a designated distribution list to notify them whether or not a follow-up report is required. A follow-up report is required if immediate protective measures were not included in the initial incident report. The responsible person (per *DDRS Incident Management and Reporting Policy*), along with input from the support team, submits follow-up reports for incidents determined to need follow-up within seven days and every seven days thereafter until the incident is resolved to the satisfaction of all entities.

The percentage of incidents reported within 0-1 days of the incident shows an encouraging improvement for this last quarter of FY2012. While the reasons for this improvement are not certain, recent provider meetings and ongoing discussion regarding the requirement to report incidents within 24 hours of discovery may be contributing factors.

Table 2. Number and Percentage of Incident Reports Reported within 24 Hours of Discovery for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Grand Total
Total Number of Incident Reports Received	2945	2782	2860	3021	2862	3048	3166	3244	3368	27296
Total Number of Incidents Reported within Time Period (0-1 days)	2156	1991	2100	2282	2141	2277	2885	2929	3104	21865
Percentage Reported within Time Period (0-1 days)	73.21%	71.57%	73.43%	75.54%	74.81%	74.70%	91.12%	90.29%	92.16%	80.10%

There is some variation in the percentage of incidents resolved within the stipulated time period (Table 3). **Providers and case managers must remain vigilant in resolving (and documenting) incidents in a timely manner.** Providing answers to the questions that were included in the *follow-up required* e-mail is important. For instance, if a person was hospitalized, include the discharge diagnoses and any discharge instructions that will prevent/reduce the likelihood of a recurrence; if there was a medication error, include whether there was any negative outcome as a result of the medication error and what steps have been taken to reduce the likelihood of additional medication errors; if there was a fall resulting in injury, include information on whether a fall prevention plan has been developed/revised and if staff have been trained/retrained

Incident Processing (cont.)

on the plan; etc. Including information on how the agency/team will monitor to ensure a similar situation does not occur in the future provides information on the longer-term resolution/systemic action.

Table 3. Number and Percentage of Incident Reports Resolved within Stipulated Time Period for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Grand Total
Total Number of Incident Reports Received	2945	2782	2860	3021	2862	3048	3166	3244	3368	27296
Number of Incidents Requiring Follow-up	1962	1741	1843	1911	288	1877	2025	1981	2047	15675
Total Number of Incidents Resolved	2944	2782	2858	3020	2844	2868	3162	3191	3036	26705
Total Number of Incidents Resolved within Stipulated Time Period (30 days)	2794	2636	2675	2836	2693	2822	2955	2994	3002	25407
Percentage of Incidents Resolved within Stipulated Time Period (30 days) (Resolved/ Received)	94.87%	94.75%	93.53%	93.88%	94.10%	92.59%	93.34%	92.29%	89.13%	93.08%

At the time the initial incident report is processed, the BQIS incident reviewer also evaluates if an incident meets the criteria of being a sentinel event. **Sentinel events are situations where a person is/was at significant risk and immediate safety measures need to be in place. Allegations of abuse, neglect and exploitation are considered sentinel events. In addition, elopement when health and welfare are at risk, choking incidents requiring intervention, suicide attempts, arrests, alleged criminal activity by a person receiving services, significant injury/health risk, (e.g., fracture, , etc.), and prohibited techniques (e.g., mechanical restraint for behavioral purposes, prone restraint, seclusion, use of aversive techniques) meet the criteria of a sentinel event. It is possible that additional incidents will be made sentinel based on the information provided (e.g., hospitalizations, fire, etc.).**

In the event an incident is made sentinel, the case manager makes either face-to-face or phone contact with the provider within 24 hours of notification of the sentinel event. Sentinel status will remain unresolved until there is documentation in either the initial incident report or a follow-up report that appropriate action(s) was taken to resolve the issue. When documentation ensuring health and welfare is confirmed, the sentinel status is resolved.

The percentage of sentinel events resolved within three days declined in April 2012 through June 2012 in relation to the percentages for the previous six months. **BQIS is reminding providers and case managers of the importance of ensuring immediate safety measures are taken.** Depending on the nature of the incident, immediate safety measures can vary; however, some of the more common safety measures include suspending staff from duty pending the outcome of the investigation for an allegation of abuse, neglect or exploitation involving staff; taking action (e.g., developing/ revising a choking prevention plan, retraining staff, providing closer supervision/monitoring at least for the short term, etc.) prior to the next time a person eats/takes medication in the event of a choking episode; and taking immediate action (e.g., staff training, revision of fall prevention plan, etc.) in the event of a fracture.

Table 4. Number and Percentage of Sentinel Events Resolved within Stipulated Time Period for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Grand Total
Total Number of Sentinel Events	354	369	392	419	387	324	483	417	469	3614
Total Number of Sentinel Events Resolved within Stipulated Time Period (3 days)	311	351	352	372	338	282	381	310	353	3050
Percentage of Sentinel Events Resolved within Stipulated Time Period (3 days)	87.85%	95.12%	89.80%	88.78%	87.34%	87.04%	78.88%	74.34%	75.27%	84.39%

Abuse, Neglect and Exploitation

The allegations of abuse, neglect, and exploitation included in Table 5 and Figure 2 are inclusive of the alleged perpetrator being a staff person, a family member/guardian, a community person, and in a small number of cases, a peer. The number of allegations of physical abuse appears to have an up and down pattern every other month. For example, there are 46 reports of allegations of physical abuse in November 2011, an increase to 58 in December, a decrease to 41 in January, and so on through June 2012. The same trend is observed for allegations of exploitation beginning in October 2011 with the only variance being two contiguous months with lower numbers in February and March 2012. There was a high of 194 allegations of neglect reported in April 2012. Allegations of neglect continue to be the most frequently reported type of allegation accounting for 45.17% of the total number of allegations of abuse, neglect and exploitation reported.

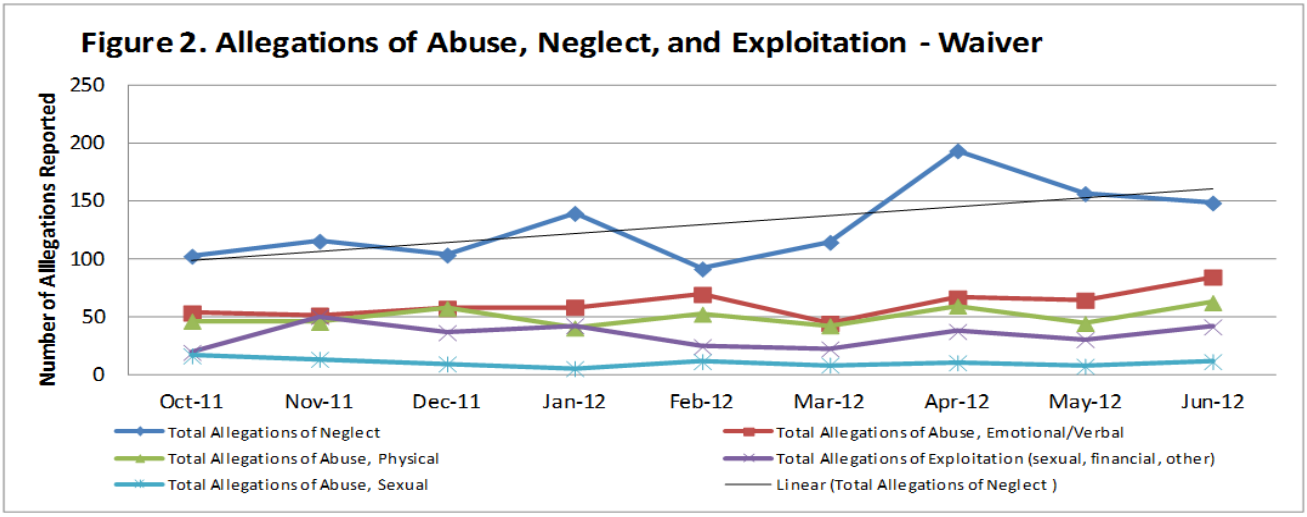
Provider agencies should develop additional training regarding allegations of abuse, neglect, and exploitation (ANE). Some items to consider including in the training include:

- Reinforcement of the overriding guideline in the **DDRS Incident Reporting and Management Policy**.
- Reinforcement of "when in doubt, err on the side of the consumer."
- Reinforcement of CMS' expectation of providers, case managers, and the state system to ensure consumers' health and safety.
- Reinforcement of the importance of honest reporting and taking both short-term and long-term corrective action.
- Reinforcement that regardless of who makes an allegation (e.g., consumer – regardless of history of false allegations, family member, direct support staff, management staff, community person, etc.), it is still an allegation and needs to be handled as such - reported, immediate protective measures taken, investigated, appropriate action(s) taken, etc.
- Discussion that providers need to continually monitor numbers of allegations of abuse, neglect and exploitation and assess which incidents were preventable and how staff should handle future situations of a similar situation differently.
- Discussion that providers need to have systems in place to trend data relative to allegations of ANE. Suggestions for trending - per person, per house, per type of allegation, per reporting person/role, substantiation rate overall, substantiation rate per type of allegation, per reporting person, per alleged perpetrator, etc. How frequently is the data reviewed? Who discusses the data? What actions are taken based on the data and discussion?
- Reinforcement of the components of the initial incident report narrative – who, what, where, when, why, how. What immediate protective measures have been taken?
- Discussion of ensuring the initial narrative report is clearly communicating why the reporting person is submitting an incident report.
- Discussion regarding appropriate and timely communication of team members. For example, submitting an incident report does not take the place of team members communicating with each other to collaborate and resolve the issues that contributed to the incident.
- Reinforcement of the definition of alleged, suspected, or actual neglect and provide some examples of neglect.
- Reinforcement of the definition of lack of consumer supports and provide some examples.
- Reinforcement of the definition of alleged, suspected, or actual financial exploitation and provide some examples.
- Discussion regarding the actions staff are expected to take if/when they identify a reportable incident, and if/when an incident is determined to be sentinel.
- Discussion regarding the fact that there are times when there isn't any clear proof/evidence to substantiate an allegation. In some cases, taking a photo of the situation can provide that proof/evidence (e.g., condition of home, staff sleeping, etc.).

Abuse, Neglect, and Exploitation (cont.)

Table 5. Allegations of Abuse, Neglect, and Exploitation Involving People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Grand Total
Total Allegations of Neglect	103	116	104	140	92	115	194	157	149	1170
Total Allegations of Abuse, Emotional/ Verbal	54	52	58	59	70	45	67	65	85	555
Total Allegations of Abuse, Physical	47	46	58	41	53	43	60	45	63	456
Total Allegations of Exploitation (sexual, financial, other)	20	51	37	43	25	23	38	31	42	310
Total Allegations of Abuse, Sexual	17	14	10	6	12	9	11	8	12	99
Grand Total	241	279	267	289	252	235	370	306	351	2590



The analysis of allegations of abuse, neglect, and exploitation since the implementation of the revised *DDRS Incident Reporting and Management Policy* on 3/1/2011 identified some issues. One of the issues was that the quality of internal investigations is quite varied. The *DDRS Mandatory Components of an Investigation Policy* (http://www.in.gov/fssa/files/Mandatory_Components_of_an_Investigation.pdf) was published with an effective date of 3/16/2012. **Providers should review their own policy and practices and obtain technical assistance in this area if appropriate.**

Another issue is that the number of allegations substantiated by each provider ranges from 0% substantiated to 100% substantiated. As noted in Table 6, allegations of neglect continue to be substantiated the highest percentage of the time; however, there is a downward trend present in the last quarter of FY2012. While the percentage of allegations of exploitation continues to be substantiated just slightly less than allegations of neglect, this category also presents with a downward trend from April 2012 through June 2012. The third category that reflects a downward trend in the substantiation rate is allegations of emotional/verbal abuse. Allegations of physical abuse are substantiated the lowest percentage of the time.

Table 6. Percentage of Allegations of Abuse, Neglect, Exploitation Substantiated for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Grand Total
Allegations of Neglect	46.60%	52.59%	57.69%	44.29%	51.09%	47.83%	62.37%	50.32%	43.62%	51.11%
Allegations of Exploitation (sexual, financial, other)	50.00%	50.98%	54.05%	44.19%	36.00%	39.13%	55.26%	48.39%	40.48%	47.10%
Allegations of Abuse, Emotional/Verbal	50.00%	40.38%	31.03%	45.76%	24.29%	51.11%	35.82%	33.85%	30.59%	36.94%
Allegations of Abuse, Sexual	23.53%	28.57%	30.00%	16.67%	16.67%	44.44%	27.27%	37.50%	33.33%	28.28%
Allegations of Abuse, Physical	31.91%	28.26%	36.21%	14.63%	30.19%	23.26%	25.00%	31.11%	20.63%	26.97%

Abuse, Neglect, and Exploitation (cont.)

Another issue is that staff are not suspended from duty pending the outcome of the investigation 100% of the time when there is an alleged, suspected or actual abuse, neglect or exploitation incident. Table 7 provides information on the percentage of times when staff were suspended in compliance with IAC 460 regulations.

Table 7. Percentage of Allegations When Staff (Alleged Perpetrator) Was Suspended Pending the Outcome of the Investigation for People Receiving Waiver Services.

Description - % of Allegations when Staff was Suspended	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Average
Allegations of Abuse, Emotional/Verbal	90.5%	79.1%	86.7%	89.4%	86.7%	88.7%	88.2%	88.9%	87.3%
Allegations of Abuse, Physical	100.0%	88.6%	60.7%	88.1%	93.1%	86.3%	93.3%	82.4%	86.6%
Allegations of Exploitation (sexual, financial, other)	100.0%	90.5%	73.9%	83.3%	85.7%	83.3%	77.8%	83.3%	84.7%
Allegations of Abuse, Sexual	66.7%	100.0%	100.0%	50.0%	100.0%	75.0%	75.0%	NA	81.0%
Allegations of Neglect	77.8%	80.2%	67.4%	75.9%	77.7%	87.7%	78.1%	80.3%	78.1%

First and foremost, in the event of an allegation of abuse, neglect or exploitation, the provider must take immediate action to ensure the health and welfare of both the alleged victim(s) and any other people receiving services. In the event a staff person is the alleged perpetrator, this includes suspending the staff from duty pending investigation by the provider. In some cases, staff were not suspended, but terminated and/or resigned immediately. In other cases, staff were not scheduled to be on duty (e.g., vacation, shift off, etc.), during the time of the investigation. Based on narrative review, other examples of situations when staff were not suspended were 1) in cases when staff other than a DSP staff person was the alleged perpetrator, 2) the consumer had a history of making false allegations, 3) a specific staff person was not identified until the investigation was concluded, and 4) the agency did not view the incident as abuse/neglect/exploitation.

Overall, staff are suspended the highest percentage of the time when there is an allegation of emotional/verbal abuse. The percentage of staff suspension for allegations of physical abuse has varied over the past nine months. The percentage of staff suspended for allegations of neglect is the lowest.

Providers should review their operating procedure to ensure this requirement is clearly stated and staff are trained to understand repercussions of being involved in an allegation of abuse, neglect, and exploitation. It is also recommended that case managers and other interested stakeholders are reminded of the requirement to suspend staff involved in allegations of abuse, neglect, and exploitation and the reason for it – to reduce risk to consumers. BQIS encourages providers to review their data regarding allegations of abuse, neglect, and exploitation along with the data presented in Tables 6 and 7.

A field for noting whether the staff person was suspended from duty pending the outcome of the investigation was added to DDRS's incident reporting database effective 11/1/2011. In November 2011 through June 2012 there were a total of 1878 allegations of abuse, neglect and exploitation by staff reported. In 37.1% of these allegations, staff were terminated due to ANE, terminated for other reasons, or resigned. The majority of allegations resulted in more than one action taken. For instance, staff are suspended from duty pending the outcome of the investigation, staff training is completed, and staff return to work. Another example is staff are suspended and subsequently terminated either due to the allegation being substantiated or due to another reason unrelated to the allegation.

Abuse, Neglect, and Exploitation (cont.)

Table 8. Totals of Actions Taken by Provider in Reports of Allegations of Abuse, Neglect and Exploitation by Staff for People Receiving Waiver Services.

Description	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Grand Total
Staff suspension	183	166	157	148	138	266	178	206	1442
Staff training	81	53	60	79	54	111	72	89	599
Staff termination due to ANE	61	63	62	39	56	57	56	63	457
Staff returned to work	60	49	37	59	33	81	37	63	419
Addressed all issues	46	38	45	30	35	57	41	43	335
Disciplinary action	24	29	24	29	27	63	35	39	270
Staff removed from home	39	24	36	25	28	25	38	25	240
Staff moved to another home	20	14	11	27	15	20	29	27	163
Other changes made	17	10	21	17	13	28	22	22	150
Staff resigned	18	10	13	13	6	42	23	11	136
Follow behavioral support plan (BSP)	20	9	17	23	8	19	8	18	122
Staff termination (for other reasons)	15	7	25	11	9	14	8	15	104
No action taken	11	14	12	5	12	14	10	11	89
Revised agency policy	16	0	6	11	5	14	10	3	65
Not applicable	0	6	12	1	7	4	14	3	47
Turned investigation over to the authorities / police involvement	6	6	5	7	1	5	5	3	38
Probation	5	1	3	6	5	3	5	1	29
Changed schedule (consumer, transportation, etc)	7	3	2	2	3	4	4	3	28
(blank)	1	1	2	1	2	0	1	8	16
Grand Total	630	503	550	533	457	827	596	653	4749

Behavioral Incidents

The number of incident reports of aggression to housemate/peer continues to be the most frequently reported type of behavioral incident with aggression to staff being the second most frequently reported. Reports of aggression to staff are trending downward during the past three months, while self-injurious behavior and property damage are both trending upward during the most recent months. For those people who have repeat behavioral incidents or who have not demonstrated improvement within the last three months, the team (including the behavioral clinician) should discuss whether a programmatic change might be beneficial.

It is imperative that all consumers who have repeat behavioral incidents have a behavioral clinician on their team and that the team continually reviews the appropriateness/effectiveness of the consumer's Behavioral Support Plan (BSP) and how well direct support staff are implementing the BSP.

Behavioral Incidents (Cont.)

Table 9. Number of Behavioral Incidents Reported for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Grand Total
Aggression to Housemate/Peer	184	138	162	142	148	197	176	177	158	1482
Aggression to Staff	133	75	70	99	110	100	121	111	99	918
Self-injurious Behavior	58	70	86	92	82	89	79	91	93	740
Elopement	70	60	68	83	71	85	71	81	64	653
Property Damage	41	52	39	45	37	39	44	55	56	408
Suicidal Thoughts/Ideations	26	26	30	44	35	31	37	38	40	307
Aggression to Family/Guardian	17	12	16	10	16	17	12	12	14	126
Aggression to Other Person	19	13	9	8	13	9	17	13	20	121
Suicide Attempt	8	8	2	8	9	8	9	8	8	68
Pica/Ingestion of Foreign Object	1	3	5	3	5	2	6	3	5	33
Assault, Sexual (for perpetrator)	3	1	0	2	4	0	0	3	1	14
Alleged Domestic Abuse	1	4	1	1	0	0	0	2	2	11
Grand Total	561	462	488	537	530	577	572	594	560	4881

Behavioral Failures

The state of Indiana prohibits the use of prone restraint (face down on the stomach), mechanical restraint, seclusion, and use of aversive techniques for a person receiving services through a waiver. Please reference the *DDRS Use of Restrictive Interventions Including Restraints Policy* (http://www.in.gov/fssa/files/Use_of_Restrictive_Interventions.pdf).

It is suggested that the teams for people who have had one of these restrictive interventions utilized review the DDRS policy, revise their operating policy/procedure, review the behavioral support plans (BSP) for the people who were involved to ensure these interventions are not part of the BSP, and retrain staff in these areas. Four people had one report of seclusion during the past quarter. While the use of a prone restraint was reported in the six month period of October 2011 through March 2012, there were no reports of prone restraint during this last quarter in FY2012. Three people had at least one report of the use of a mechanical restraint for behavioral purposes in the last quarter for a combined total of four reports. And lastly, one person had a report of an aversive technique during the past quarter (Table 10).

The *Community Services Reporter* published by the National Association of State Directors of Developmental Disabilities Services (NASDDS) provides updates on which states prohibit the use of prone restraint and seclusion. Neighboring states that also prohibit the use of prone restraint and seclusion are Illinois, Michigan, and Ohio.

Additional information regarding the danger of utilizing a prone restraint can be found at:

- *Asphyxial Death during Prone Restraint Revisited; A report of 21 cases.* O'Halloran R, et al. The American Journal of Forensic Medicine and Pathology 21(1) March 2000;
- *National Review of Restraint Related Deaths of Children and Adults with Disabilities: The Lethal Consequences of Restraint.* Equip for Equality – A Special Report from the Abuse Investigation Unit, 2011.

It is also suggested that the teams for people who have had multiple restraints (e.g., manual/physical, PRN medications) utilized in the past six months receive technical assistance on behavioral intervention strategies.

Of the 32 people who were arrested during this quarter, six of them were arrested more than once.

Behavioral Failures (Cont.)

Table 10. Number of Behavioral Failures Reported for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Grand Total
Restraint, Manual/Physical Restraint Technique - Behavioral Purposes	121	134	108	129	103	114	76	118	111	1014
PRN Medication - Behavioral Purposes	80	79	82	81	53	77	77	79	90	698
Arrested	11	10	19	14	18	13	9	14	16	124
Seclusion	1	0	8	1	0	1	2	1	1	15
Restraint, prone	1	1	1	2	3	1	0	0	0	9
Restraint, Mechanical Restraint Technique - Behavioral Purposes	2	0	0	1	1	0	1	2	1	8
Use of Aversive Technique	0	1	0	0	0	0	0	0	1	2
Grand Total	216	225	218	228	178	206	165	214	220	1870

Medication Errors

A significant increase in reported medication errors occurred with the implementation of the revised *Incident Reporting and Management Policy* effective 3/1/2011 which expanded the criteria for reportable medication errors, a significant. The number of medication errors reported in March 2012 is the lowest number reported during the past 16 months.

From analysis of the types of medication errors being reported, it was noted there were incident reports being submitted indicating the person did receive a medication; however, it was given outside the window of time. In order to capture those instances, an additional coding option of *medication error, given outside window* was added 11/1/2011. Medications must be given within a half hour of the time that is listed on the medication log (Centers for Medicare & Medicaid Services [CMS] *Interpretive Guidelines*; Core A Medication Administration Training). This means that you have a half hour before the medication is due, and a half hour after it is due to administer the medication.

The category of medication error reported most frequently has remained consistent over the past 16 months – medication error-missed dose, not given (Table 11). While there have been a couple of downward trends in this category of medication error, the overall number is significant. Medication errors-wrong dose, showed a steady downward trend in the number of reports from November 2011 to March 2012. The grand total of reported medication errors shows a slight downward trend over the past three months (April 2012 to June 2012).

Table 11. Medication Errors Reported for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Grand Total
Medication error, missed dose, not given	326	308	306	292	276	301	344	321	320	2794
Medication error, wrong dose	90	100	87	83	72	68	81	67	69	717
Medication error, wrong medication	23	23	41	47	40	24	23	27	19	267
Medication error, given outside window	0	11	16	16	26	12	16	21	16	134
Medication error jeopardizing health and safety	2	2	1	2	2	1	1	2	1	14
Medication error, wrong route	2	0	0	1	0	0	0	1	1	5
Grand Total	443	444	451	441	416	406	465	439	426	3931

Medication Errors (Cont.)

Providers are required to assure that its staff responsible for administering medication are trained on an annual basis, as stated in DDRS Policies. In addition, providers should have a system in place that includes:

1. **a monitoring system with routine observations of medication passes (A sample medication pass checklist is in BQIS's 10/1/11-3/31/12 Incident Data and Recommendations, available at http://www.in.gov/fssa/files/Incident_Communication_7.9.12(1).pdf);**

2. **staff that have made medication errors receive refresher medication administration training, and**

3. **routine review, and revisions as necessary, to assure provider's written policies/procedures match those being implemented.**

Choking Episodes Requiring Intervention

A choking episode requiring intervention is considered a life-threatening event. When BQIS receives an incident report of a person that had a choking episode requiring intervention, incident reviewers review the initial incident report, follow-up report(s), and other pertinent documentation to identify the actions that have been taken to prevent another choking episode. **What safety measures have been put in place before the next time the person eats/drinks/takes medications?** The interdisciplinary team might also identify future action(s) as a longer term remedy, but it is important to first implement some immediate safety measure(s).

There have been several choking episodes requiring intervention where the person already had a choking prevention plan and still choked. In these cases, the current plan was not effective for some reason. **How did the team address the failure of the current plan?** It is possible the plan itself was fine, but the failure was due to another variable (e.g., staff were not implementing the plan correctly, the appropriate supervision was not in place, etc.). If those factors contributed to the choking episode, the immediate safety measure should address those identified variables.

Many choking prevention/dining plans have a statement, "food should be cut into bite-size pieces." While at first glance this statement appears as an adequate guideline for staff, there is a lot of room for interpretation and as a result, the person is at risk. **It is recommended that teams review current choking prevention/dining plans and replace the phrase "bite-size" with a more descriptive and measured term that is appropriate to the individual person such as "pieces no bigger than a quarter," "pieces the size of a quarter to half-dollar," "sandwich is to be cut into ¼ pieces," etc. It is also recommended that the choking prevention/dining plan include visual cues of the actual size of the item (e.g., an actual-size picture of a quarter, a visual cue staff can use to verify that food of a different original shape is presented to the person correctly, etc.). In addition, if there are food items that are troublesome and/or prohibited due to the person's choking risk, these food items should be listed in the choking prevention/dining plan.**

Dining plans, as well as any other risk plans, should be consistently implemented in all settings (e.g., home, day program site, restaurants, church events, the family home, other special events, etc.). Without proper implementation, the risk of choking increases. **There were five deaths (across all funding sources) due to asphyxiation (associated with food/pica/objects/medication/vomitus) during October 2011 through March 2012. There were an additional five choking deaths (across all funding sources) this quarter (April 2012 through June 2012).** The total number of choking episodes requiring intervention are noted in Table 12.

A checklist of questions/probes regarding a choking episode is available on the BQIS website (http://www.in.gov/fssa/ddrs/2635.htm) and should be used by the team to address any identified variables that contributed to the choking episode. The checklist can also be utilized as a proactive risk management and educational tool for teams.

Choking Episodes Requiring Intervention (Cont.)

Table 12. Number of Choking Episodes Requiring Intervention Reported for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Grand Total
Choking Requiring Intervention	15	12	11	11	8	11	11	11	11	101

Emergency Room Visits and/or Hospital Admissions (Medical and Psychiatric)

The number of incidents associated with ER Visits (for medical reasons) has varied during the past nine months with a monthly average of 531.5 ER visits for medical reasons calculated on nine months of data (Table 13). While the reasons for an ER visit or a hospital admission can be varied, the underlying factor is that a change in status (real or perceived) was noted. A variety of fact sheets and resource materials relative to recognizing and responding to changes in health status and medical conditions/situations are available on the BQIS website (http://www.in.gov/fssa/ddrs/2635.htm). Providers are encouraged to incorporate these materials into their operating policies/procedures and individual-specific risk plans and ensure staff are trained.

The number of in-patient hospitalizations for medical reasons presents two trends, an upward trend in late fall/early winter (November 2011 through February 2012) and a downward trend in spring/early summer (April 2012 through June 2012).

Both ER visits and in-patient hospitalizations for psychiatric reasons are trending upward over the past three months.

BQIS strongly recommends that the teams for people who have had multiple ER visits and/or hospital admissions within the past three months, take a close look at the person's diagnoses, the risk plans in place, staffing levels, the home environment, and other relevant factors and have an honest discussion among the team members (including the consumer, guardian, physician, etc.) on whether the current setting can meet the person's current needs.

Table 13. Number of ER Visits/Hospital Admissions Reported for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Grand Total
Emergency Room Visit - Medical	510	466	529	512	540	557	547	587	536	4784
In-patient Hospitalization - Medical	163	152	157	170	174	173	178	163	147	1477
Emergency Room Visit - Psychiatric	49	48	49	75	57	71	60	64	75	548
In-patient Hospitalization - Psychiatric	43	23	34	44	43	45	43	46	56	377

Resources Regarding Incident Reporting and Management

The link to the DDRS Incident Reporting and Management Policy is http://www.in.gov/fssa/files/Incident_Reporting_and_Management_3-1-11.pdf.

In addition, the link to the Frequently Asked Questions (FAQs) relative to Incident Reporting is http://www.in.gov/fssa/files/FREQUENTLY_ASKED_QUESTIONS_TABLE_OF_CONTENTS_3-8-11.pdf